

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of issue with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83	30222				
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Matilda Horner Andrews						Nov. 19, 1983			5 PM						
3. SEX			4 RACE	5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			White	MONTH	DAY	YEAR	86			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland			U.S.						Dorchester MD.						
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Cambridge			Dorchester Genl. Hospital			Homemaker			21613						
13a. STATE			13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			13f. ADDRESS		
Md.			Dor.	Cambridge			YES <input type="checkbox"/>			601 William street			Webster		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME									
Thomas					Horner	Malissa									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
NO			220-44-6121			Thomas B. Andrews, Jr., Hampton, Va.,									
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypovolemic Shock															
2859 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hernia															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 11/19/1983 to 11/19/1983 that (I) (we) last saw the deceased alive on 11/19/1983, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/21/83						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 22, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Green Lawn Cemetery			23d. LOCATION CITY OR TOWN Cambridge COUNTY Dor. Md. STATE						
24. FUNERAL DIRECTOR NAME Thomas Funeral Home, Cambridge, MD. 21613			ADDRESS NOV 28 1983			25. DATE REC'D BY FUNERAL DIRECTOR John J. Connelly			25b. FEE OR TRAVEL EXPENSE \$100.00						
BP _____															
DHMH - 16 50M 1/81 (VRA 15, 4)															

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 30223			
1 - FOR STATE REGISTRAR			REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR				
CLARENCE L. BALTIMORE						Nov. 29, 1983					11:08 A.M.				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.	
M			N			MONTH DAY YEAR			70			MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			
Vienna, Md.			U.S.A.									DORCHESTER, MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
CAMBRIDGE			DORCHESTER GEN. HOSPITAL			RET.									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			
MARYLAND			DORCHESTER			E. NEW MKT.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			RT. 1, Box 69A 21631			
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME									
LEVIN			— BALTIMORE			MILLIE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No			—			—			Mrs. Pauline C. Baltimore, RFD 1, Box 69A.						
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain stem infection</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCO</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>(R) renal and retroperitoneal hematoma</u>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>① Pneumothorax resolved.</u>															
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>M. J. Hallen MD</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial			Dec. 3, 1983			Thompsonstown Cemetery			Thompsonstown, Dorchester, Md.						
24. FUNERAL DIRECTOR NAME <u>Hampshire-Hawkins Federalsburg</u>			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
						DEC 5 1983			<u>John J. Smith</u>						

BB

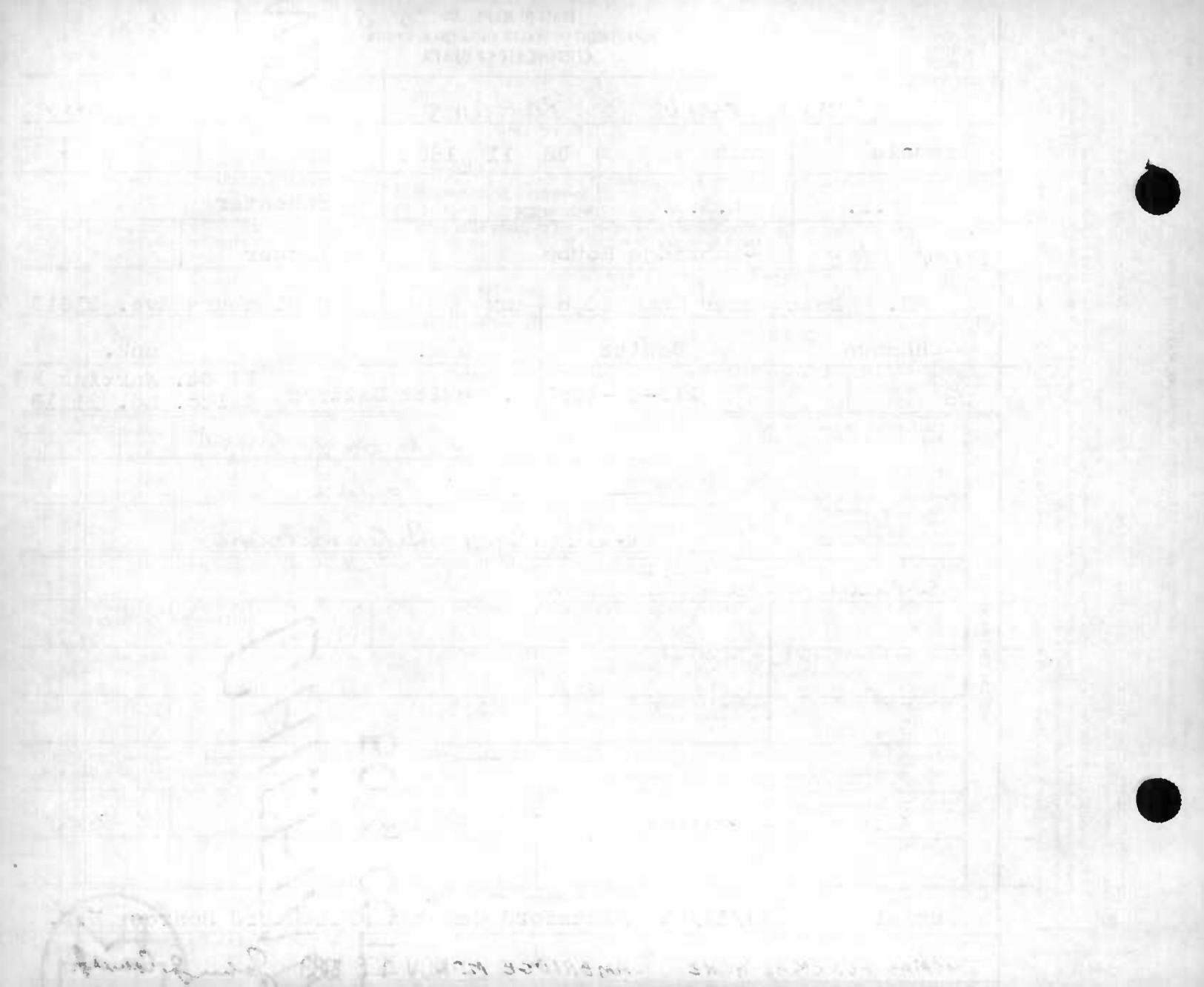


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83	30224				
FOR STATE REGISTRAR			REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Clara Belle			Battams			11 7 83						8:45 P M					
3. SEX female			4. RACE white			5. DATE OF BIRTH 08 11 1884			6. AGE (IN YEARS LAST BIRTHDAY) 99			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester			MD.					
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker			12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE Md.			13b. COUNTY Dorchester			13c. CITY OR TOWN Cambridge			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 520 Glenburn Ave. 21613					
14. FATHER'S NAME FIRST unknown			MIDDLE DeWitt			15. MOTHER'S MAIDEN NAME FIRST unk.			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 213-48-2291			17. INFORMANT E. DeWitt Battams		ADDRESS 12 St. Martins Rd Balto. Md. 21218
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4409</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DOUE TO, OR AS A CONSEQUENCE OF (b) <u>C. H. Failure</u>																	
DOUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u>																	
19a. MEDICAL CERTIFICATION			19b. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Dysautonomia</u>			19c. DATE OF OPERATION			19d. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21e. LOCATION STREET			CITY OR TOWN COUNTY STATE		
21f. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21g. DEGREE MD			21h. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			21i. ADDRESS			22c. DATE SIGNED 11-7-83					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE <u>John J. Connealy</u>			22c. DATE SIGNED 11-7-83											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 11/11/83			23c. NAME OF CEMETERY OR CREMATORIAL Pittsford Cemetery			23d. LOCATION CITY OR TOWN Pittsford Monroe N.Y.					
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME			25a. DATE REC'D. BY REGISTRAR NOV 16 1983			25b. REGISTRAR'S SIGNATURE John J. Connealy											
ADDRESS CAMBRIDGE MD																	



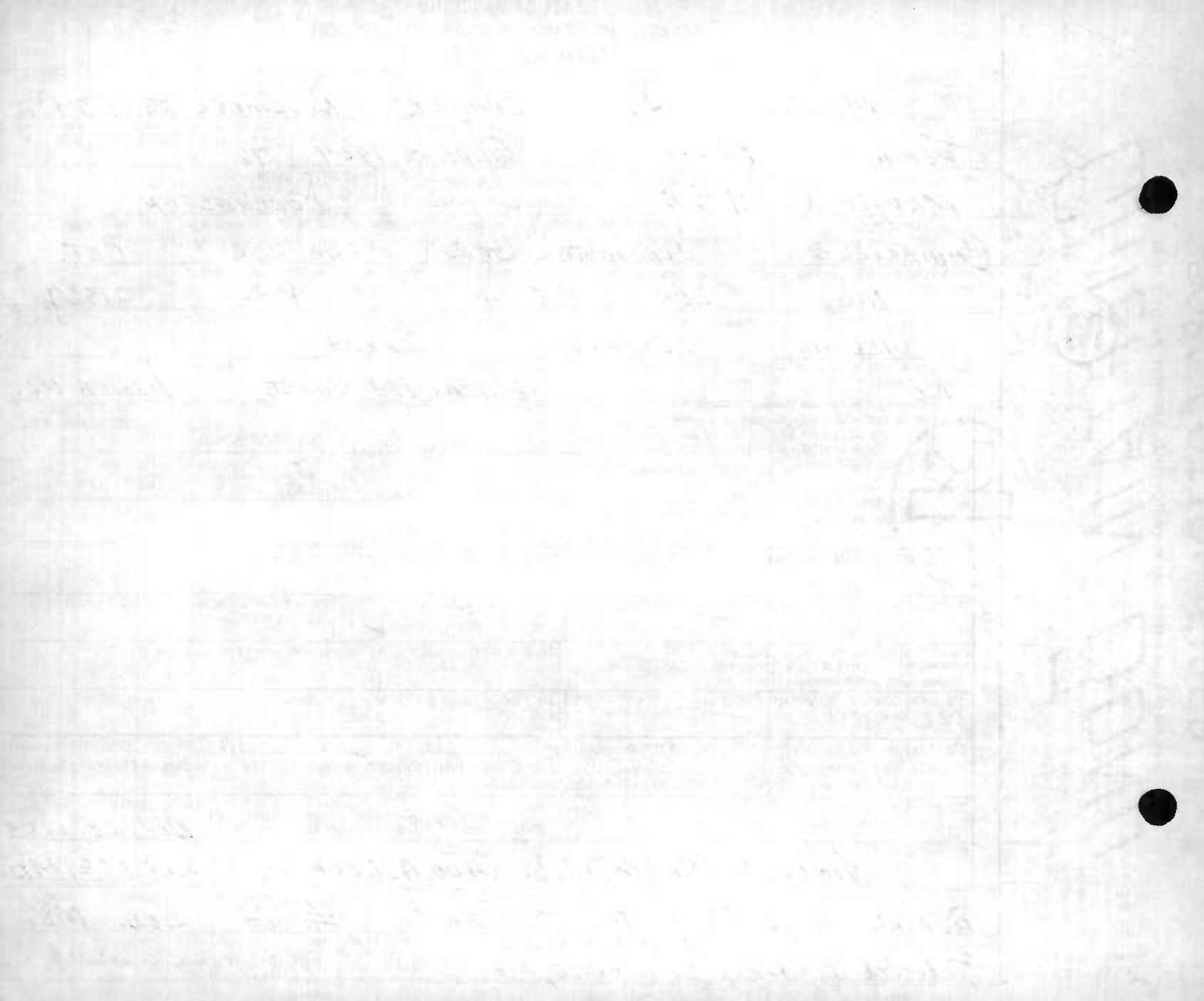
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned to you, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Please sign page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 24 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

30225

1. DECEASED-NAME (Type or print)	First MYRTLE	Middle S.	Last CAMPER	2a. DATE OF DEATH Month NOVEMBER	Day 23, 1983	Year 4:30 PM	2b. HOUR				
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH SEPT. 2, 1907			6. AGE (In years last birthday) 76	YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH SORCHESTER			Md.					
10. CITY OR TOWN OF DEATH CAMBRIDGE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SORCHESTER GEN.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER			12b. KIND OF BUSINESS OR INDUSTRY RET.						
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.	13b. COUNTY SOR.	13c. CITY OR TOWN VIENNA	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER RFD. 21869							
14. FATHER'S NAME First WILLIAM	Middle DENNARD	15. MOTHER'S MAIDEN NAME First SARAH									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	16b. SOCIAL SECURITY NO. 4140	17. INFORMANT ELIZABETH CHASE				Address VIENNA, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Pneumonia & Empyema DUE TO, OR AS A CONSEQUENCE OF (b) ASH & ventr. Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) Ghenni Leg Ulcer						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH —		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) —							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. —		City or Town —		County —		State —	
22a. I certify that (I) (this hospital) attended the deceased from 11/21, 1983 , to 11/22, 1983 , that (I) (we) last saw the deceased alive on 11/21, 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Chimenti		22c. DEGREE —	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED Nov. 23, 1983					
22d. PHYSICIAN'S NAME (Type) VINODRAI MEHTA, M.D.		22e. ADDRESS 400 AURORA ST. CAMBRIDGE, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11-26-83	23c. NAME OF CEMETERY OR CREMATORIAL MT. PLEASANT			23d. (Town) Hanover	(County) DOC. MD.	(State) —				
24. FUNERAL DIRECTOR Judie C. Lewis CAMBRIDGE, MD.		25a. REC'D BY REGISTRAR DATE NOV 29 1983			25b. REGISTRAR'S SIGNATURE John J. Coniff						



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										30226							
										REG. NO.							
1. FOR STATE REGISTRAR		1a. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
		Howard		Earl				Depew		Nov. 14		1983			3:45p		
3. SEX		4. RACE		5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
male		white		06		26		1900		83		YEARS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED		NEVER MARRIED		<input checked="" type="checkbox"/>		<input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
N.Y.		U.S.A.		WIDOWED		<input type="checkbox"/>		DIVORCED		<input type="checkbox"/>		<input type="checkbox"/>		Dorchester			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Cambridge		Dorchester General Hosp.										Camb. Wire Cloth Co.					
USUAL RESIDENCE (IE NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS									
14. FATHER'S NAME FIRST George		MIDDLE		LAST Depew		15. MOTHER'S MAIDEN NAME FIRST Lillie		MIDDLE		Grant							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-24-4605		16c. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5570		17. INFORMANT Loretta S. Depew		ADDRESS Item #13									
18. CAUSE OF DEATH Enter only one cause per line for 10, 1b, and 1c PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)				DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS / PERITONITIS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost				DUE TO, OR AS A CONSEQUENCE OF (c) INFARCTED LEFT COLON						DAYS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION 11/16/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED G.I. HEMORRHAGE PERITONITIS		19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IE EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (1) this hospital attended the deceased from 11/03, 19 83, to 11/14, 19 83, that (1) we lost saw the deceased alive on 11/14, 19 83, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (1) we (did) (did not) view the body after death.																	
22b. SIGNATURE DAVID B. STOECKLE				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/16/83									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID B. STOECKLE MD		22e. ADDRESS 400 Aurora St Cambridge, MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIES) burial		23b. DATE 11/17/83		23c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park		23d. LOCATION CITY OR TOWN Cambridge		CITY OR TOWN Dor.		COUNTY		STATE Md.					
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME		ADDRESS CAMBRIDGE MD.		25a. DATE REC'D. BY REGISTRAR NOV 21 1983		25b. DATE REC'D. BY REGISTRAR'S CLERK John J. Curran											

1981 S.V. 3

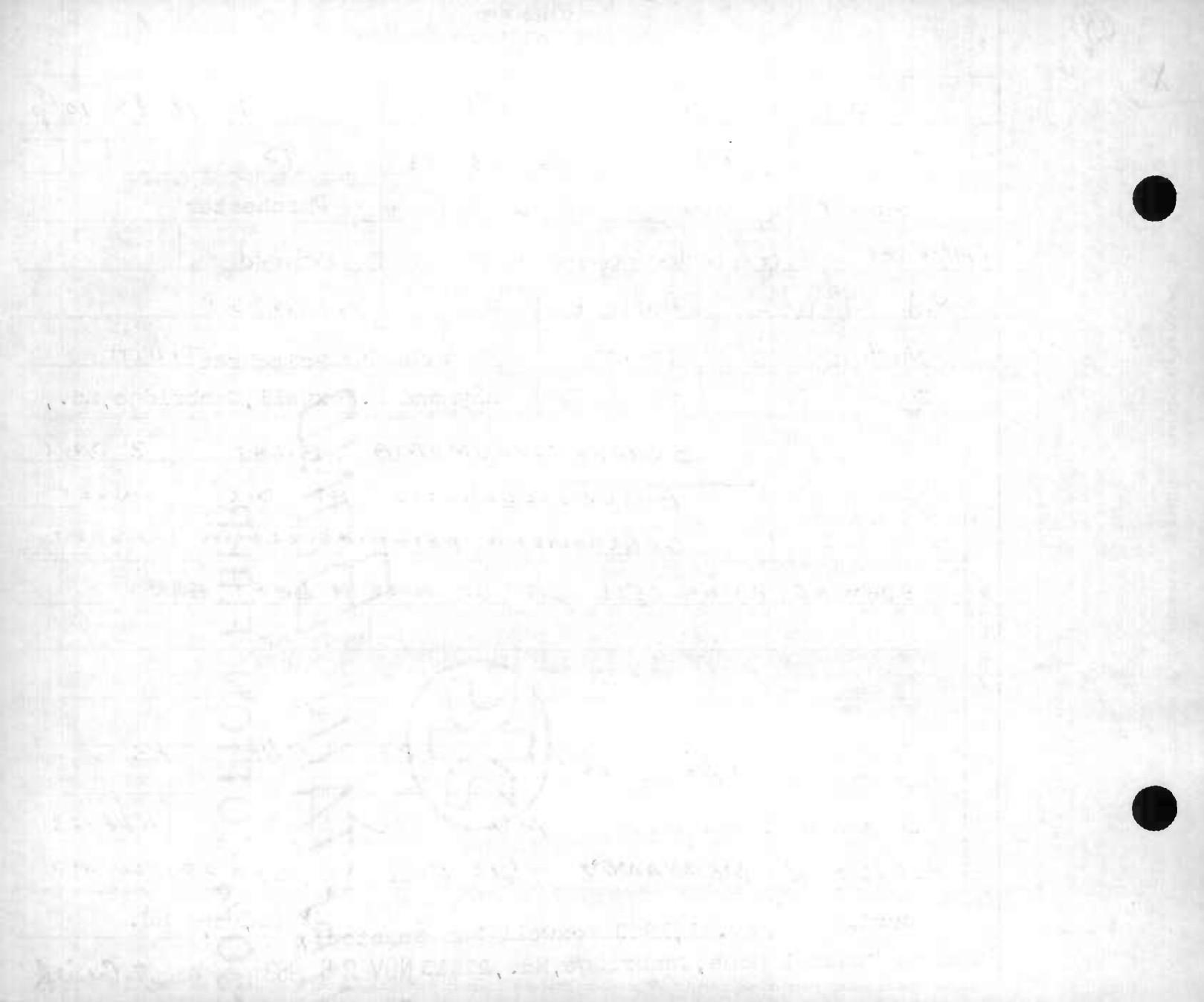
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										30221				
										REG. NO.				
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			LAST			2d DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR
			Agulia V. Foxwell						11 18 83					10 ¹⁵ PM
3. SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
F			CAU			MONTH 6 DAY 13 YEAR 88			95		MONTHS		DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MD-USA			USA								Dorchester MD.			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
CAMBRIDGE			Dorchester General Hosp						retired					
13a. STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Md			HARLICK						RT 1, Box 85-D 21613					
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME			LAST					
FIRST Milton			Truitt			MISSOURI Pritchett Truitt			ADDRESS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO			220-10-6916			Raymond L. Foxwell, Cambridge, Md.,			3 DAYS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)														
4140 BRONCHOPNEUMONIA, BILAT														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HT. DIS.				
DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIOSCLEROSIS										UNDER				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
ERODING BASAL CELL CA OF NOSE + LEFT EAR														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11/18 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			DEGREE			22c. DATE SIGNED								
Alfred R. Maryanov			MD			11/18/83								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS								
ALFRED R. MARYANOV						610 RACE ST., CAMBRIDGE, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY TOWN Crapo, Dor		COUNTY	STATE		
Burial			Nov. 21, 1983			Foxwell Fam Cemetery								
24. FUNERAL DIRECTOR						24a. DATE REC'D. BY REGISTRAR			24b. REGISTRAR'S SIGNATURE					
Thomas Funeral Home, Cambridge, Md., 21613						NOV 28 1983			John J. Caniff					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "No" item 18 showing any injury, or other traumatic event, the medical examination must be completed on date _____.

MEDICAL CERTIFICATION

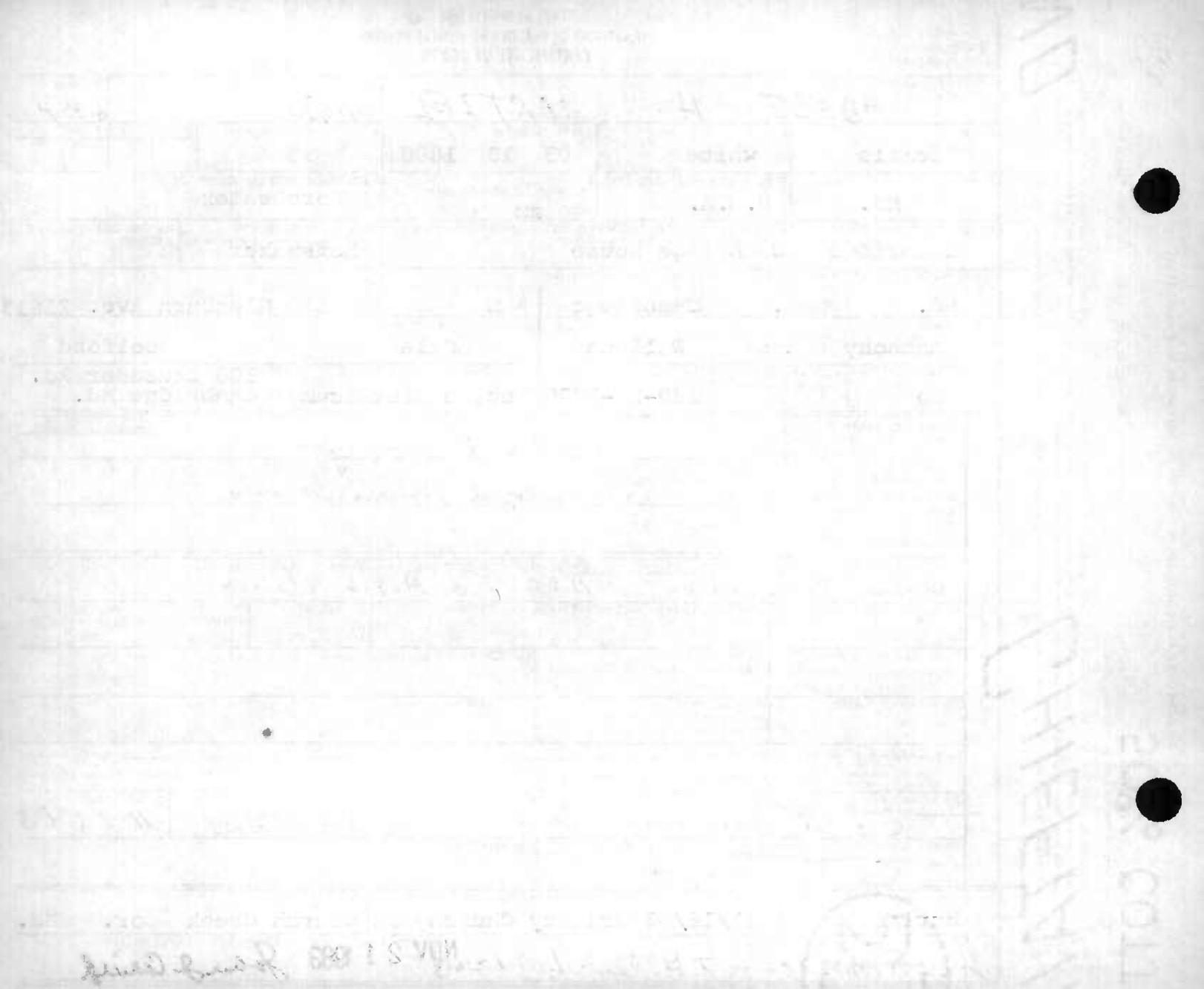
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										30228				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Dudley J							Gordon		11		15	83	1 P.M.	
3. SEX			4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male			Caucasian		MONTH 9		DAY 26		YEAR 09		MONTHS 74		YEARS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Massachusetts			U.S.A.								Dorchester			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Cambridge			Dorchester General Hospital		Administrator				Red Cross					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										MD. 21613				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE						
Maryland		Dorchester		Cambridge		YES <input checked="" type="checkbox"/>		1401 School St., Apt. #2						
14. FATHER'S NAME FIRST			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
PATRICK					GORDON		DELIA				NEE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			(YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
YES			WW II		578-07-6280		Mrs. Bette Brooks Gordon, same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) 4140 VENTRICULAR TACHYCARDIA TO SARTVIL TERMINALLY										1+ YEAR				
DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE ARTERIOSCLEROTIC HEART DISEASE										1+ YEAR				
DUE TO, OR AS A CONSEQUENCE OF (c) Previous massive anterior and inferior myocardial infarction 1978														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (1) (this hospital) attended the deceased from Jan 18 1983 to Nov 18 1983, that (2) (we) last saw the deceased alive on Nov 15 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (we) did not view the body after death.														
22b. SIGNATURE Donald Dudley										DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11-15-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald R. McWilliams			22e. ADDRESS 308 Gay St. Cambridge MD. 21613											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation			23b. DATE Nov. 16, 1983		23c. NAME OF CEMETERY OR CREMATORIAL Security Process		23d. LOCATION CITY OR TOWN Baltimore Co., Maryland							
24. FUNERAL DIRECTOR NAME Curran Funeral Home, 308 High St., Cambridge,			ADDRESS Md. 21613		25a. DATE REC'D. BY REGISTRAR NOV 18 1983		25b. REGISTRAR'S SIGNATURE John L. Curran							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certifier must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 30329								
1. FOR STATE REGISTRAR			2a. DATE OF DEATH 11/13/83							2b. HOUR 6:30 P.M.								
1. DECEASED NAME (TYPE OR PRINT) ADELE H. HARTZEL			MIDDLE LAST			6. AGE (IN YEARS LAST BIRTHDAY) 95			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.							
3. SEX female			4. RACE white			5. DATE OF BIRTH MONTH 03 DAY 13 YEAR 1888			7. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester			
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.			13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 520 Glenburn Ave. 21613							
14. FATHER'S NAME FIRST Anthony MIDDLE Ross LAST Wallace			15. MOTHER'S MAIDEN NAME FIRST Adele MIDDLE Woolford															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 220-26-3439							17. INFORMANT Louise Linthicum			ADDRESS 300 Crusader Rd. Cambridge Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis								
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Organic B. Syndrom, As CVD o A. Fibrillation																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE S. Deemay MD										22c. DEGREE			22d. DATE SIGNED 11-13-83					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) S. Deemay										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial										23b. DATE 11/16/83			23c. NAME OF CEMETERY OR CREMATORIAL Trinity Churchyard			23d. LOCATION CITY OR TOWN Church Creek COUNTY Dor. STATE Md.		
24. FUNERAL DIRECTOR NAME John Thomas 700 Court St. Cambridge, Md. 21613 ADDRESS										NOV 21 1983			25b. REGISTRAR'S SIGNATURE John J. Conroy					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be filled in by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										30230			
										REG. NO.			
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR		
			Charles Franklin Hill						Nov. 6, 1983		3 pm		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
male			white			08 24 1916			67 yrs		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.		
Md.			Dor.						Dorchester				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NURSING HOME, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Cambridge			801 Church St.			plumber			ret.				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		
Md.			Dor.			Cambridge					801 Church St. 21613		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Frank Henry Hill			Nettie Wheatley										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) <input checked="" type="checkbox"/> YES			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
(IF YES, GIVE GRADE OR RATES) WW 2			217-10-8755			Hazel D. Hill			Item # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
1629 <i>Carcinoma of right Lung</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.										18 months			
b. <i>with generalized metastases</i>										18 months			
c. <i></i>													
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
19b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 3/26/82, 19, to 11/7/83, 19, that (I) (we) lost the deceased alive on 10/4/82, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Lawrence Maryanov</i>			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11/7/83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lawrence Maryanov MD</i>			22e. ADDRESS 610 Race St Cambridge, Md 21613										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 11/9/83			23c. NAME OF CEMETERY OR CREMATORIAL Md. Veterans Cem.			23d. LOCATION CITY OR TOWN Beulah		COUNTY Dor.		
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME			ADDRESS CAMBRIDGE MD.			25a. DATE REC'D. BY REGISTRAR NOV 16 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Carrick</i>				

First find of 887 C V

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FILER OR TO FUNERAL DIRECTOR: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGE 5, AND PAGE 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 30231	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED			MONTH	DAY	YEAR	2b. HOUR	
Mary Ann			Elsie	Holliday		<input checked="" type="checkbox"/>	<input type="checkbox"/>	11-21	1983	AM	M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.	2d. HOUR			
female	white	01 07 1896	87							2d. HOUR			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED <input checked="" type="checkbox"/>			2c. DATE PRONOUNCED DEAD			9. BALTIMORE CITY OR COUNTY OF DEATH		
Md.		U.S.A.			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Nov. 21, 1983			Dorchester		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY	
Cambridge		504 Governors Ave.					sewing machine					operator	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			MD. 21648	
Md.		Dorchester		Madison					RURAL				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST				
Levin			Insley	Rachel					Moore				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
no		215-14-3476			Frances Bloodsworth			Item #11					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Carcinoma, stomach with metastases												?	
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>													
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?	
												<input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>John Mace Jr. M.D.</i> M.D. Deputy MEDICAL EXAMINER													
EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr. M.D. ADDRESS Cambridge, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE		
burial		11/23/83		Joppa Churchyard			Madison		Dor.		Md.		
24. FUNERAL DIRECTOR NAME <i>THOMAS FUNERAL HOME</i> ADDRESS CAMBRIDGE MD.													
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 050 - 2 1983 <i>John J. Connel</i>													
DH/MH-17 (VR A15 ME (5)) 15M 2/80													

(M)

Revised 200-300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 1 shows any injury, or other traumatic event, the medical examiner must be consulted once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												30232			
												REG. NO.			
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			NELLIE Blanche HORSMAN						11-26-83			12 30 AM			
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		white		11-15-1892			91			MONTHS	YEARS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			10 CITY OR TOWN OF DEATH					
Md		USA					Dorchester			Cambridge					
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
EASTERN Shore Hospital Center				HOUSE WIFE				Own Name							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Md				Wicomico		Bivalve		Rural Rt.		Zip 21814					
14 FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME Annie. E. Misted				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				17 INFORMANT ADDRESS			
William B. McSweeney								200-01-2828A				MEDICAL RECORDS EASTERN Shore Hospital			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Presumptive Hypoxia 4860 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
(b) Presumptive Pneumonia															
{ DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Debilitation															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
Multinfarct Dementia Diabetes Mellitus															
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
		N/A		N/A				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19		21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2				N/A							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				N/A							
22a. I certify that (1) this hospital attended the deceased from Nov. 26, 1983, to 19_____, that (1) (we) last saw the deceased alive on Nov. 25, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (1) did not view the body after death.															
22b. SIGNATURE Charles Ragan MD												22c. DEGREE			
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												22d. DATE SIGNED 11/26/83			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS													
Charles Ragan MD		P.O. Box 800, Cambridge, Md. 21613													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN COUNTY STATE								
Burial		11/27/83		Bivalve Com.			Bivalve, Md.								
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Conradine Ann Mandie Bualas, Rd.				NOV 29 1983			John J. Conigli								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do it.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be consulted before the death certificate is signed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 30233	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR November 23 1983							2b. HOUR 7 pm _M	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Margaret G Hubbard						05 22 1902			81 YRS		
3. SEX female			RACE white			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) teacher-public schools			12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE Md.			13b. COUNTY Dorchester			13c. CITY OR TOWN Cambridge			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Thomas B. Hubbard			15. MOTHER'S MAIDEN NAME Nettie			13e. STREET ADDRESS Horns Point, 21613			LAST Henry		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 213-24-0079			17. INFORMANT Thomas S. Venable			ADDRESS 412 Leonard Lane Cambridge Md.		
18. CAUSE OF DEATH (Enter only one cause per line for 18a, b, and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4149			DUE TO, OR AS A CONSEQUENCE OF (b). Acute renal failure			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (c). Coronary Artery Disease			4 days					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Organic Brain Syndrome										5 yrs	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/20/83, 19, to 11/23/83, 19, that (I) (we) lost saw the deceased alive on 11/23/83, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 11/23/83	
22b. SIGNATURE Lawrence Manyanor			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence Manyanor, MD			22e. DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 11/26/83			23c. NAME OF CEMETERY OR CREMATORIAL CHRIST CHURCHYARD			23d. LOCATION CITY OR TOWN CAMBRIDGE DOR. MD. COUNTY STATE		
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME			ADDRESS CAMBRIDGE MD,			25a. DATE REC'D. BY REGISTRAR DEC 01 1983			25b. REGISTRAR'S SIGNATURE John J. Conigli		

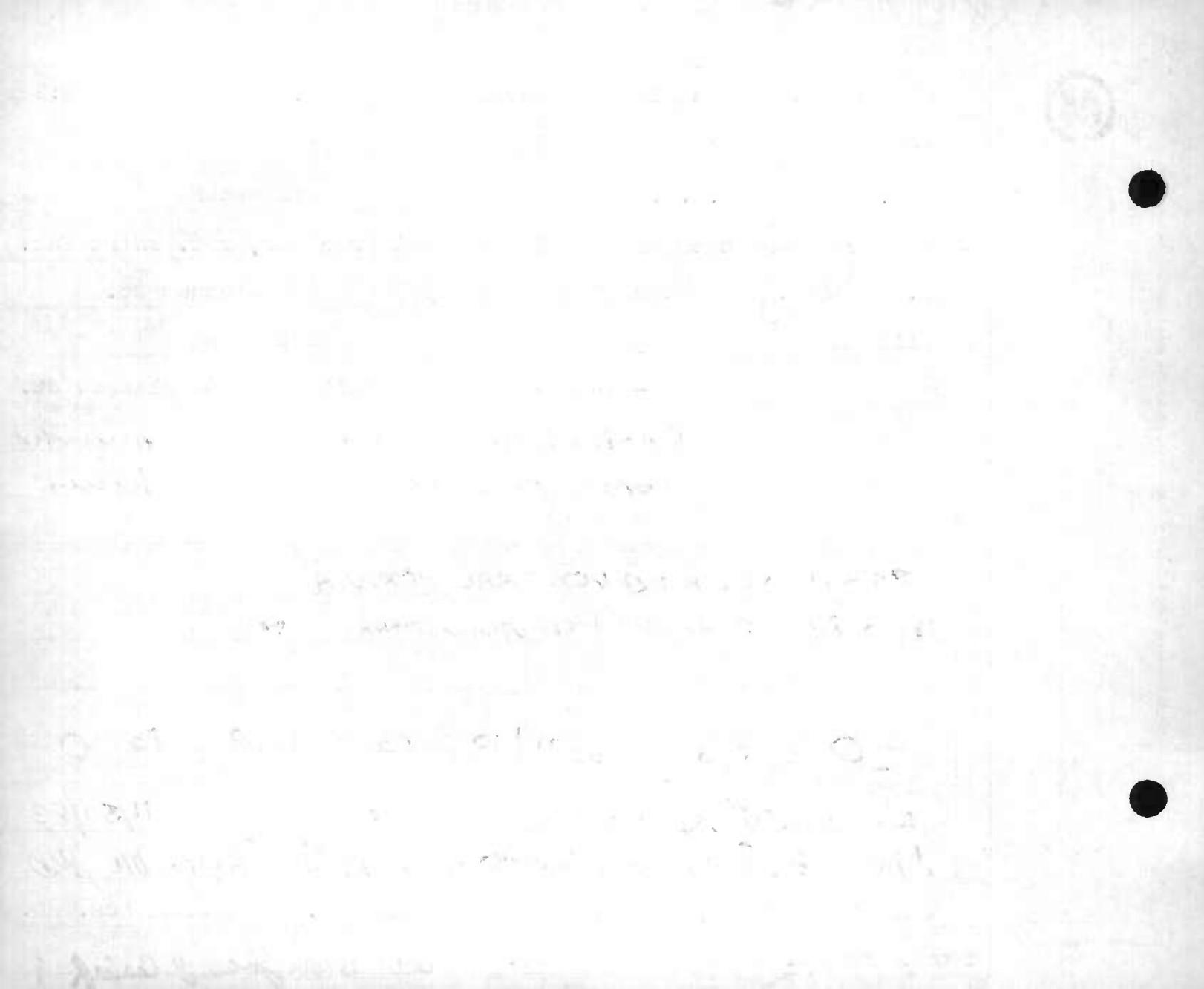


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 30234			
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR Nov. 19 1983							2b. HOUR 11:30a M			
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST										
Lettie Phillips Hubert													
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Jan 8 1892			6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester						
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) manager, ret.			12b. KIND OF BUSINESS OR INDUSTRY shirt fac.						
13a. STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge			13d. INSIDE CITY LIMITS? XX YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 902 Glasgow St.				
14. FATHER'S NAME FIRST William MIDDLE LAST Lord						15. MOTHER'S MAIDEN NAME FIRST Ida MIDDLE LAST Catherine							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-07-7267		17. INFORMANT Charles Phillips			ADDRESS 1104 Glasgow St.						
18. CAUSE OF DEATH (Enter only one cause per line for 1a, b, and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes hours			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost { (b) HEART FAILURE { (c) 													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) STRANGULATED VENTRAL HERNIA													
19a. DATE OF OPERATION 11/10/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED STRANGULATED VENTRAL HERNIA			20a. AUTOPSY? NO		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? NO						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (he/she) attended the deceased from 11/10 1983 to 11/19 1983 , that (I) (we) last saw the deceased alive on 11/19 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE David B. Stockle										22c. DATE SIGNED 11/30/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID B. STOCKLE MD		22e. ADDRESS 400 AURORA ST. CAMBRIDGE, MD.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 11/22/83		23c. NAME OF CEMETERY OR CREMATORIAL E. NEW MARKET CEM			23d. LOCATION CITY OR TOWN E. NEW MARKET DOR. MD.						
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE MD.		ADDRESS			25a. DATE REC'D. BY REGISTRAR DEC 08 1983			25b. REGISTRAR'S SIGNATURE John J. Conroy					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be filled in by the funeral director, page 5 by the medical examiner.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												30235			
												REG. NO.			
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			WILBERT HUBERT HUGHES			2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE			CAUC			26 MONTH 8 DAY 07			76 YRS			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Dorchester Co.		USA					DORCHESTER								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
CAMBRIDGE		DORCHESTER GENERAL			LABORER RETIRED										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
		Md		Dore		CMB		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1st 4 Box 35					
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		BURTON					
		MILTON				HUGHES		BOSIE ROBERTSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO		214-07-9046			MADIE METS			228-5208			2 12 hrs				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION													
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) GENERALIZED ATHEROSCLEROTIC CARDIO VASCULAR DISEASE										YES			
		(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
							<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) this hospital attended the deceased from 11/12/83 to 11/13/83, that (I) we saw the deceased alive on 11/13/83, and that in (my) opinion death occurred on the date and hour and from the causes stated above.															
22b. SIGNATURE				DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
HUBERT L. PERRY				MD						11/13/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			503 BYRN ST CMB MD.								
HUBERT L. PERRY															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION								
BURIAL		11/6/83		DORCHESTER MEM PK			COLUMBIAN			C. DOR. MD.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
THOMAS FUNERAL HOME CAMBRIDGE MD				NOV 9 1983			John J. Conroy								

mixed bushy tree 200 ft.

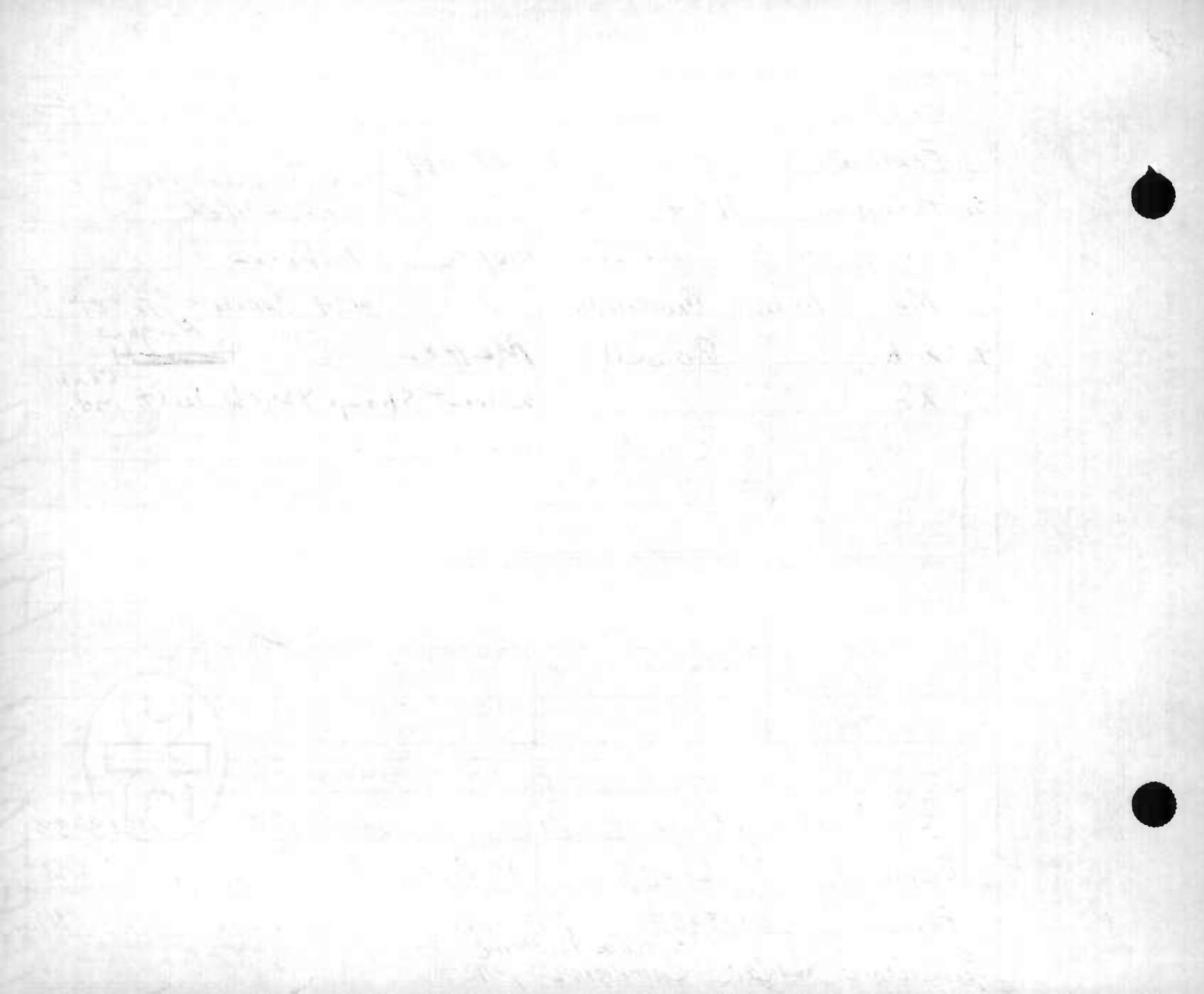
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										30236					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)									2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR HRS. MIN.		
<i>Jaetha Johnson</i>									11/13/83				4:00 P.M.		
3. SEX FEMALE			4. RACE Black			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS						
						1 28 19			64 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester						
10. CITY OR TOWN OF DEATH Cambridge, Md			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester Gen. Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labourer			12b. KIND OF BUSINESS OR INDUSTRY 21613						
13a. STATE Md		13b. COUNTY Dor.		13c. CITY OR TOWN CAMBRIDGE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 424 CHARLES STREET						
14. FATHER'S NAME FIRST Treah		MIDDLE 		LAST Bowell		15. MOTHER'S MAIDEN NAME FIRST Mather			MIDDLE Hughes						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 4275			17. INFORMANT Wilbert Sharp			ADDRESS 424 Charles St. Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if any (b) _____ Due to, or as a consequence of (c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>E MacLaughlin</i>										DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11-13-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edmund J. MacLaughlin			22e. ADDRESS 10 Aurora St. Cambridge, Md 21613												
23a. BURIAL, CREMATION, REMOVAL (S)			23b. DATE 11-18-83			23c. NAME OF CEMETERY OR CREMATORIAL BETHEL			23d. LOCATION CITY OR TOWN Cambridge		COUNTY Dor.	STATE Md.			
24. FUNERAL DIRECTOR NAME <i>Frederick C. Lohair</i>			ADDRESS ST. CLAIR F. HOME CAMBRIDGE, MD.			25a. DATE REC'D. BY REGISTRAR NOV 14 1983			25b. REGISTRAR'S SIGNATURE <i>J. Langlois</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified. page 3 hours after death

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83 30237			
										REG. NO.			
1 - FOR STATE REGISTRAR		2d. DATE OF DEATH MONTH DAY YEAR								2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		FIRST Frederick		MIDDLE Kircher	Kircher			11 - 1 - 83		11 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BOSTON			93 YRS.			
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BOSTON GENERAL Hosp.								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY DERKESIDE		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Willowmere Lane		21613		
14. FATHER'S NAME FIRST George		MIDDLE	LAST Kicher		15. MOTHER'S MAIDEN NAME FIRST Katherine			MIDDLE	LAST Kugler				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. No -		16c. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4511 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			17. INFORMANT Rosemarie Albites Cambridge, MD			ADDRESS Willowmere Lane			
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4511 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		18b. DUE TO, OR AS A CONSEQUENCE OF (b) DEEP VEIN THROMBOSIS LEFT LEG 18c. DUE TO, OR AS A CONSEQUENCE OF (c) POOR MOBILITY DUE TO ADVANCED PARKINSON DISEASE 1+ yrs						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH < 24 hrs					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a JUVENILE DEMENTIA SECONDARY TO CEREBRAL ATROPHY DUE TO CEREBRAL ARTERIOSCLEROSIS													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERRING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/18/80</u> to <u>11/1/83</u> , that (I) (we) last saw the deceased alive on <u>11/1/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE Donald L. McWilliams, M.D.										DEGREE			
22c. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD L. McWILLIAMS, M.D.										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	DATE SIGNED 11-1-83		
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 11-4-83		23c. NAME OF CEMETERY OR CREMATORIAL East New Market Cem.			23d. LOCATION E. New Market, Dor., MD			23e. DATE REC'D. BY REGISTRAR NOV 9 1983			
24. FUNERAL DIRECTOR Zeller Funeral Home, East New Market, MD		25a. REGISTRAR'S SIGNATURE John J. Conroy			25b. REGISTRAR'S SIGNATURE								

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS INCURRED, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 4 AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												3 0 2 3 8 REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR		
Frances			Z.	Kline		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11-21-83			A M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YR.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD		
female		white		10 26 1892		91						Nov. 21, 83 30 AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester					
Md.			U. S. A.											
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3 West End Ave.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3 west End Ave. 21613						
14. FATHER'S NAME FIRST Louis			MIDDLE Zoeller			15. MOTHER'S MAIDEN NAME FIRST Margaret			LAST Ittle					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 182 28 8108			17. INFORMANT D Frances Matthews Item #13			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF <u>4100</u> Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last</u> (b) <u>Arteriosclerotic C.V. Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Mins.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>John Mace Jr.</i>			TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER			DATE SIGNED 11/23/83					
EXAMINER'S NAME (TYPE OR PRINT)			John Mace Jr. M.D.			ADDRESS			CAMBRIDGE, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE burial 11/23/83			23c. NAME OF CEMETERY OR CREMATORIAL OUR LADY GOOD COUNSEL CHURCHYARD			23d. LOCATION CITY OR TOWN SECRETARY MD.					
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME			ADDRESS CAMBRIDGE MD.			25. DATE REC'D. BY REGISTRAR DEC 2 1983			26. REGISTRAR'S SIGNATURE <i>John J. Carroll</i>					
DHMH-17 (VRA15 ME (5)) 15M 2/80														



1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												30239	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Ruth MANSER			Ruth		MANSER	11/18/83			11	18	83	10 AM	
3. SEX			4. RACE White			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Female			CAUC.			MONTH 10 DAY 19 YEAR 15			68			IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.	
New Jersey			U.S.A.						Dorchester			MD.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Cambridge, Md.			Dorchester General Hosp.			Housewife			21620				
13a. STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Md.			Kent			Chestertown			RFD Quaker Neck				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
John Gerhardt			Florence Mae Longshaw										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
no			143-24-9552			Earl Patterson			RFD Quaker Neck				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:						Chestertown, Md.							
IMMEDIATE CAUSE (a) 4100			DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			Cardio-Respiratory Arrest							
DUE TO, OR AS A CONSEQUENCE OF (c) possible Acute m/													
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
Diabetes Mellitus													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
19b.													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (he/she) attended the deceased from 11/18/83, 19_____, to 11/18/83, 19_____, that (I) (we) last saw the deceased alive on 11/18/83, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE E. Tanman			22c. DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11-18-83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 17 Franklin St. Cambridge, MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/20/83			23c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery			23d. LOCATION CITY OR TOWN Chestertown, Md. COUNTY STATE				
24. FUNERAL DIRECTOR NAME Willis Wells			ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR NOV 22 1983			25b. REGISTRAR'S SIGNATURE John G. Cawley				

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

240

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event within 72 hours after death.

1. DECEASED NAME (Type or print)		First AKA William ELZEEY	Middle Marine	Lost Marine	2a. DATE OF DEATH Month 11 Day 27 Year 1983	2b. HOUR 8:45 AM
3. SEX MALE		4. RACE NEGRO		S. DATE OF BIRTH 12/24/1893	6. AGE (In years last birthday) 93 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN 00
7a. BIRTHPLACE (State or foreign country) CISA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH DORCHESTER	
10. CITY OR TOWN OF DEATH CAMBRIIDGE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glasgow Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Campb.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Dor.	13c. CITY OR TOWN Camb.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 6012 Robbins St. 21613	
14. FATHER'S NAME First JOHN Middle WESLEY Lost Marine		15. MOTHER'S MAIDEN NAME First NANCY Middle - Last Marine			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 214-079527 17. INFORMANT Mildred McQuire 219 Zeppelin Ave. 3	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH min						
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD</p> <p>DUE TO, OR AS A CONSEQUENCE OF (c)</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>VRS</p>						
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)</p> <p>DEMENTIA, RENAL FAILURE</p>						
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
<p>22a. I certify that (1) this hospital attended the deceased from 11/18, 1953, to 11/27, 1983, that (1) (we) last saw the deceased alive on 11/27 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.</p>						
22b. SIGNATURE Hubert L. Ferry MD		DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 11/27/83
22d. PHYSICIAN'S NAME (Type) HUBERT L. FERRY		22e. ADDRESS 503 BYRN ST. CAMB. MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-3-83	23c. NAME OF CEMETERY OR CREMATORIAL Bethel Ame. Cem.		23d. LOCATION (City or Town) Cambidge Dor. Md.	(County) Dor. (State) Md.
24. FUNERAL DIRECTOR Bardley Funeral Home Camb. Md. 21613		ADDRESS		25a. REC'D BY REGISTRAR DEC 01 1983	25b. REGISTRAR'S SIGNATURE John J. Conroy	



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30241

FOR
1 - STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)FIRST
Clarence

MIDDLE

LAST

Matthews

2a. DATE KNOWN
OF ESTI-
DEATH MATEDMONTH DAY YEAR
11-6-1983 P.M.

3. SEX

4. RACE
Male Negro5. DATE OF BIRTH
MONTH DAY YEAR

4-3-1907

6. AGE (IN YEARS
LAST BIRTHDAY)

70 yrs.

7. IF UNDER 1 YR.
MONTHS DAYSIF UNDER 24 HRS.
HOURS MIN2c. DATE
PRONOUNCED
DEADMONTH DAY YEAR
Nov. 6, 1983 12:15 P.M.7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Va.

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED
WIDOWEDNEVER MARRIED
DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

Dorchester Co.

MD.

10. CITY OR TOWN OF DEATH

Cambridge

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

DOA Dorchester General Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Ret. Laborer

12b. KIND OF BUSINESS
OR INDUSTRY

13a. STATE

Md.

13b. COUNTY

Dor.

13c. CITY OR TOWN

Cambridge

13d. INSIDE CITY LIMITS?
YES NO 13e. STREET ADDRESS
735 Washington St. 216B

14. FATHER'S NAME

John

MIDDLE

LAST

Matthews

15. MOTHER'S MAIDEN NAME

Sally

MIDDLE

LAST

Boggs

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

Yes

(IF YES, GIVE WAR OR DATES)

WW I

16b. SOCIAL SECURITY NO.

214-07-9282

17. INFORMANT

Susie Matthews, Cambridge, Md.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Few Mins

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:

4100

IMMEDIATE CAUSE (a) Coronary occlusion

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.{ (b) _____
DUE TO, OR AS A CONSEQUENCE OF

{ (c) _____

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES NO 21a. EXTERNAL CAUSE WAS
UNDERLYING OR
CONTRIBUTING CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE NOT WHILE
AT WORK AT WORK 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner .ACTUAL
SIGNATURETITLE (SPECIFY)
M.D. Deputy MEDICAL EXAMINERDATE
SIGNED 11/12/83EXAMINER'S NAME
(TYPE OR PRINT)

John Mace Jr. M.D.

ADDRESS

Cambridge, Md.

23a. BURIAL, CREMATION, REMOVAL
(SPECIES)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION
CITY OR TOWN

COUNTY STATE

Burial

11/12/83

Bethel Cemetery

Cambridge, Dor. Md.

County State

24. FUNERAL DIRECTOR
NAME

St. Clair Funeral Home

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

NOV 14 1983 John L. Smith

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR PERSONAL USE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME(5))
15M 7/77

M



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1A. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

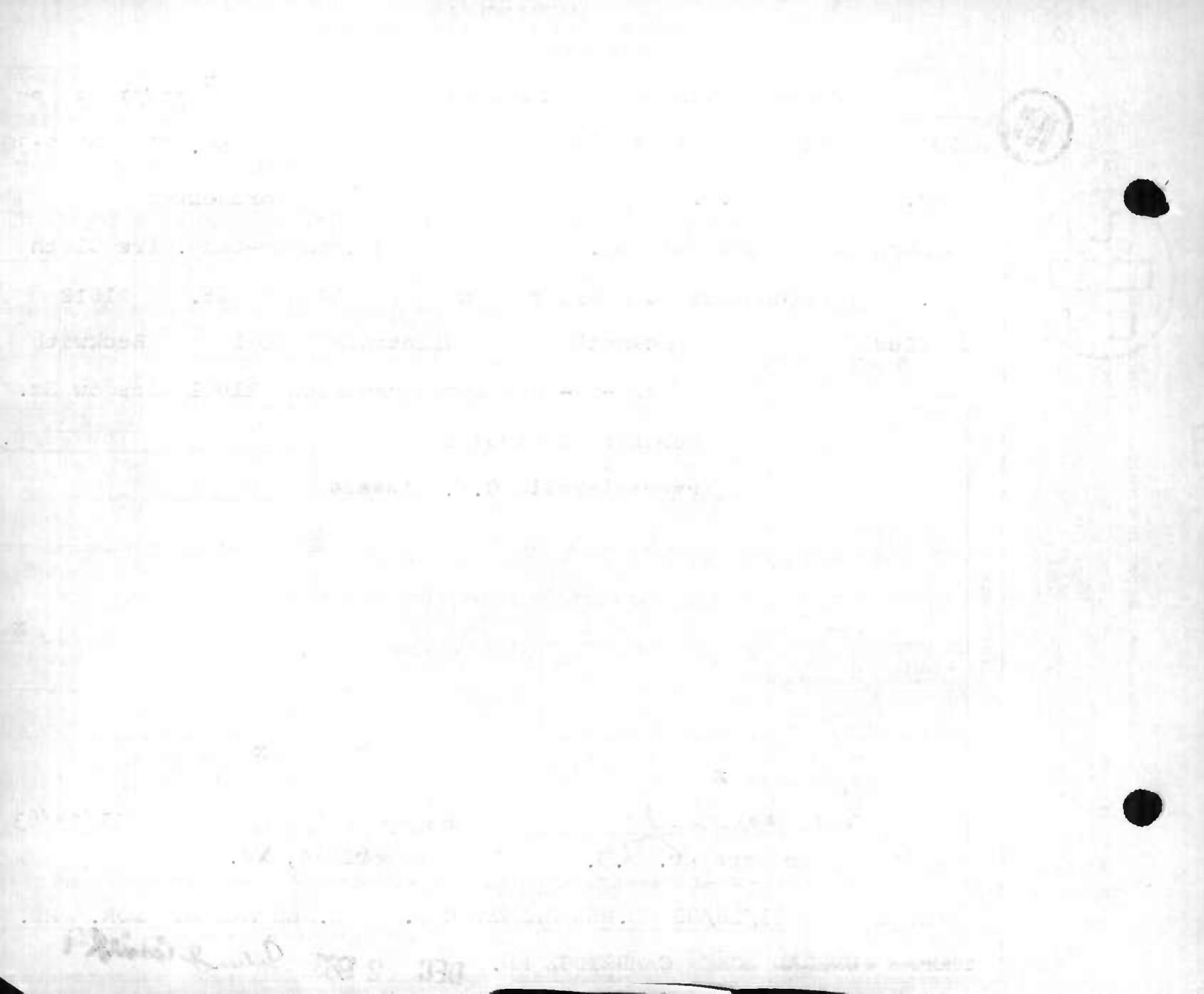
1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30242

REG. NO.

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	7a. DATE KNOWN OF EST. DEATH MATED	MONTH	DAY	YEAR	2b. HOUR	
Francis Vincent McKnett						<input checked="" type="checkbox"/>	11/21	1983		PM	
SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR LAST BIRTHDAY	6. AGE (IN YEARS) YRS.	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
male	white	02 13 1921	62	MONTHS	DAYS	HOURS	Nov.	21	1983	2:30 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH							
Md.	U.S.A.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Dorchester							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY
Cambridge	420 Muir St.					crimper-Camb. Wire Cloth					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS						
Md.	Dorchester	Cambridge	420 Muir St.		21613						
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		LAST						
Charles		McKnnett	Clintonia		Bell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS								
no	218-16-5458	Sarah Roberson	X1001 Glasgow St.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Artersclerotic C.V. Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Few Mins.</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?			
								<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>John Mace Jr. M.D.</u> M.D. Deputy MEDICAL EXAMINER											DATE SIGNED <u>11/23/83</u>
EXAMINER'S NAME (TYPE OR PRINT)			TITLE (SPECIFY)								
John Mace Jr. M.D.			Cambridge, Md.								
ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		COUNTY	STATE	
burial			11/25/83	E. NEW MARKET CEM.			E. NEW MARKET		DOR.	MD.	
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR								
THOMAS FUNERAL HOME			25b. REGISTRAR'S SIGNATURE <u>John J. Carroll</u>								
ADDRESS			DEC 2 1983								
CAMBRIDGE MD.											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

BP _____

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 30243

1. DECEASED NAME (TYPE OR PRINT)		FIRST LLOYD	MIDDLE	LAST MEEKINS	2a. DATE OF DEATH 11/19/83	MONTH	DAY	YEAR	2b. HOUR 9:00 PM	
3. SEX MALE		4. RACE CAU.		5. DATE OF BIRTH MONTH MAY DAY 4, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 74		IF UNDER 1 YEAR YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER				
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION DORCHESTER GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WATERMAN		12b. KIND OF BUSINESS OR INDUSTRY SHELLFISH		
13a. STATE MARYLAND		13b. COUNTY DORCHESTER		13c. CITY OR TOWN CAMBRIDGE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 603 Academy St. 21613		
14. FATHER'S NAME FIRST JOHN		MIDDLE D.	LAST MEEKINS	15. MOTHER'S MAIDEN NAME FIRST LILLIAN		MIDDLE D.	LAST Woodlin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-14-7320		17. INFORMANT Mrs. Dorothy Withey, 430 Oakley St.		ADDRESS Cambridge, Md. 21613				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		RESPRATORY FAILURE 1629 DUE TO, OR AS A CONSEQUENCE OF (b) SMALL CELL CARCINOMA OF LUNG DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) EMPHYSEMA										
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (1) (this hospital) attended the deceased from 9/03/1983 to 11/19/1983, that (1) (we) last saw the deceased alive on 11/12/1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Michael A. Moskewicz		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/19/83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. MOSKEWICZ		22e. ADDRESS 503 Byen St. Cambridge MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Nov. 22, 1983		23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Pk. Cen.		23d. LOCATION CITY OR TOWN Airey, Cambridge, Dorchester		COUNTY	STATE Md.	
24. FUNERAL DIRECTOR NAME CURRAN FUNERAL HOME,		ADDRESS 308 High St., Cambridge,		25a. DATE REC'D. BY REGISTRAR NOV 28 1983		25b. REGISTRAR'S SIGNATURE John J. Curran Jr.				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Form 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Form 2 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be consulted.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 302 44			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Marie M. Nichols						11			20	83	6:10 P.M.		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female			Caucasian		MONTH 06 DAY 10 YEAR 10		73			MONTHS YRS.		HOURS MIN	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			8. CITIZEN OF WHAT COUNTRY?		9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		10. DIVORCED <input type="checkbox"/>			11. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland			U.S.A.		WIDOWED <input type="checkbox"/>					Dorchester County MD.			
12. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY						
Cambridge			Eastern Shore Hospital Center		Clerical		Retail Store						
13. STATE			14. COUNTY		15. CITY OR TOWN		16. INSIDE CITY LIMITS?		17. STREET ADDRESS				
Md.			Caroline		Federalsburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		213 Academy Ave.				
18. FATHER'S NAME			FIRST	MIDDLE	LAST	19. MOTHER'S MAIDEN NAME		20. ADDRESS					
George			R.		Nichols	Anna		Rte. 1 Box 116A Rhedesdale, Md.					
21a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			21b. SOCIAL SECURITY NO.		21c. INFORMANT		22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
			216 05 8175		Jesse Wedman								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Diabetes mellitus DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Urinary tract infection													
19a. DATE OF OPERATION NA			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) saw the deceased alive on 11-20 1983							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NA			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11-7-1983 to 11-20-1983, that (I) (we) last saw the deceased alive on 11-20 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Evangeline Garcia, M.D.			22c. DEGREE			22d. DATE SIGNED 11-20-83							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) EVANGELINE M. GARCIA, M.D.			22f. ADDRESS ESH&C, Cambridge, Md 21613										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Enombtment			23b. DATE 11-25-83			23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Cemetery			23d. LOCATION CITY OR TOWN Federalsburg				
24. FUNERAL DIRECTOR Fowler Williams - Federalsburg, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR NOV 28 1983			25b. REGISTRAR'S SIGNATURE John J. Conroy				

Dissertations

A 2.0 μ molar

សាខាអាស់នឹងក្រុមហ៊ុនអាមេរិកខ្លួន ដើម្បីបង្កើតការងារជាមួយក្រុមហ៊ុនអាមេរិក។

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2025 RELEASE UNDER E.O. 14176

10

88

-14-

82-4611 X
earlier, sparser, more scattered in distribution

Wolff, John - 1870-1940 - *John Wolff*

¹⁰ HOSPITAL OF ATTENDING PHYSICIAN. The law requires that the death certificate be executed 24 hours after death.

Maintain by the hospital or attending physician.
TO FUTERAL DIRECTOR: After this certificate has been signed by the attending physician and stamped it and in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper, page 2, and file with the State Director of Health and Mortal Remains office to bury, exhumation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

30 2 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
William Russell Parker						Nov. 13, 1983							
3. SEX	Male	4. RACE	Black	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	IF UNDER 24 HRS		
				Feb.	18,	1907		76 yrs.	YRS	MONTHS	DAYS	HOURS	MIN
7. BIRTHPLACE (STATE OR FOREIGN (COUNTRY))		7b. CITIZEN OF WHAT COUNTRY?		8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		U.S.A.					Dorchester Co. MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY	
Cambridge		Dorchester General Hospital					Farmer					Farming	
13a. STATE Maryland						13b. COUNTY Dorchester		13c. CITY OR TOWN Vienna		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 1 Box 31 21869	
14. FATHER'S NAME FIRST Robert B. Parker						15. MOTHER'S MAIDEN NAME FIRST Clara Dennard							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO		214-16-4493		Essie M. Banks, 2801 Elsinor Ave., Baltimore									
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Esophageal Ca</u> <u>1509</u> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE					
22a. I certify that (1) this hospital attended the deceased from 19 83 to 19 83, that (2) we last saw the deceased alive on 11 13 19 83, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (If we (did) not view the body after death.)													
22b. SIGNATURE <u>MD</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 11/13/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MD</u>		22e. ADDRESS <u>MD</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 17, 1983		23c. NAME OF CEMETERY OR CREMATORIUM Vienna Cemetery		23d. LOCATION CITY OR TOWN Vienna		COUNTY Dorchester		STATE Md.			
24. FUNERAL DIRECTOR NAME Michael F. Eskow		ADDRESS 216 N. Main St., Federalsburg		25a. DATE REC'D. BY REGISTRAR NOV 18 1983		25b. REGISTRAR'S SIGNATURE <u>See attached</u>							

Handout 8.1 VIII

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 THROUGH 8. REFER TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 30245			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			XX	MONTH	DAY	YEAR	2b. HOUR		
WILLIE LEE ROBINSON						<input checked="" type="checkbox"/>				11-4-83	19		M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.	2c. DATE PRONOUNCED DEAD			11-4-83	19	2d. HOUR
MALE	BLACK	JULY 28, 1917 66	S.										7:20A		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Dorchester County			MD.	
GEORGIA		USA													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			LABORER			RET.	
Cambridge		Dorchester General Hospital (DOA)													
13a. STATE MARYLAND		13b. COUNTY DORCHESTER		13c. CITY OR TOWN CAMBRIDGE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		615 RACE STREET			21613		
14. FATHER'S NAME FIRST BEN		MIDDLE		LAST ROBINSON		15. MOTHER'S MAIDEN NAME LEOLA		16. ADDRESS		ROBINSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 265-12-6180		17. INFORMANT GORDON ROBINSON		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alcoholism Arteriosclerotic cardiovascular disease 3030 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?										
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY				
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Maragita A. Korell</i>		TITLE (SPECIFY) Assistant			MEDICAL EXAMINER										
EXAMINER'S NAME (TYPE OR PRINT)		Maragita A. Korell, M.D.			ADDRESS 111 Penn Street										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMBURIAL		23b. DATE 11-09-83			23c. NAME OF CEMETERY OR CREMATORIAL WAUGH			23d. LOCATION CITY OR TOWN CAMBRIDGE			COUNTY DOR.				
24. FUNERAL DIRECTOR NAME <i>Frederick C. Delair</i>		ADDRESS ST. CLAIR F. HOME CAMBRIDGE, MD.						25a. DATE REC'D. BY REGISTRAR NOV 14 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Connelly</i>				
BP _____															
DHMH - 17 (VR A15 ME (5))															
20M 4/82															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 47						
1. DECEASED NAME (TYPE OR PRINT)			FIRST <u>LETROY</u>	MIDDLE <u>S</u>	LAST <u>SIMMONS</u>			2d. DATE OF DEATH MONTH <u>NOV</u>			DAY <u>29</u>	YEAR <u>1983</u>	2b. HOUR <u>8:24 PM</u>			
3. SEX <u>MALE</u>			4. RACE <u>Cauc</u>			5. DATE OF BIRTH MONTH <u>11</u> DAY <u>20</u> YEAR <u>11</u>			6. AGE (IN YEARS LAST BIRTHDAY) YEARS <u>72</u>			IF UNDER 1 YEAR MONTHS <u>0</u>		IF UNDER 24 HRS HOURS <u>0</u>		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MOBILIA</u>			7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>DORCHESTER</u>			MD.				
10. CITY OR TOWN OF DEATH <u>CAMBRIDGE</u>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>DORCHESTER</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>WATERMAN</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>SHELFISH</u>							
13a. STATE <u>Md</u>			13b. COUNTY <u>DORCHESTER</u>			13c. CITY OR TOWN <u>CHURCHVILLE</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <u>STAR RT BOX 702</u>				
14. FATHER'S NAME FIRST <u>ALLIE</u>			MIDDLE <u></u>	LAST <u>SIMMONS</u>	15. MOTHER'S MAIDEN NAME FIRST <u>BONIE</u>			MIDDLE <u></u>	LAST <u>MELEKINS</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>WW II</u>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>220-16-9736</u>			17. INFORMANT <u>MRS OLIVE SIMMONS</u>			ADDRESS <u>STAR RT BOX 702</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>4274</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u></u>										6 hours						
(b) <u>VENTRICULAR FIBRILLATION</u>										30 min						
(c) <u></u>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION <u>NONE</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u></u>			21f. LOCATION STREET <u></u>			CITY OR TOWN <u></u>		COUNTY <u></u>		STATE <u></u>			
22a. I certify that (1) (this hospital) attended the deceased from <u>11/26</u> , 19 <u>83</u> , to <u>11/26</u> , 19 <u>83</u> , that (1) (we) last saw the deceased alive on <u>11/26</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (I did) (did not) view the body after death.																
22b. SIGNATURE <u>HUBERT L. FERRY</u>			22c. DEGREE <u></u>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>11/26/83</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HUBERT L. FERRY</u>			22e. ADDRESS <u>503 BYRN ST. CAMB. MD.</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>NOV. 29, 1983</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Md. Veterans Cem.</u>			23d. LOCATION CITY OR TOWN <u>Hurlock</u>			COUNTY <u>Dorchester</u>		STATE <u>Md.</u>		
24. FUNERAL DIRECTOR <u>CURRAN FUNERAL HOME</u>			25a. DATE REC'D. BY REGISTRAR <u>NOV 29 1983</u>			25b. REGISTRAR'S SIGNATURE <u>J. CURRAN</u>										



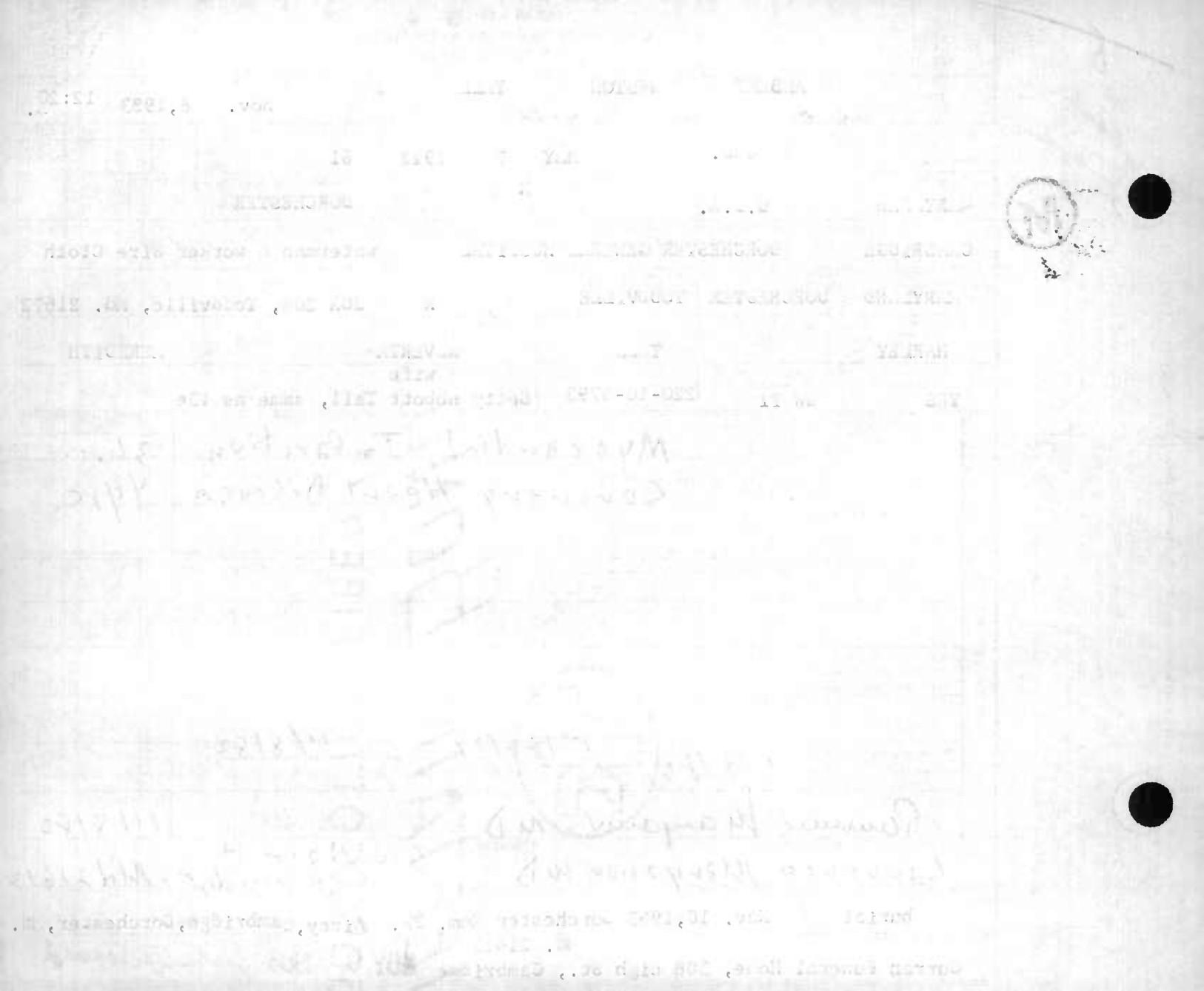
X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												302-3 Y8
												REG. NO.
1 - FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST ALBERT	MIDDLE WESTON	LAST TALL	2a. DATE OF DEATH			MONTH DAY YEAR	2b. HOUR	
	<i>Albert</i>			<i>W.</i>	<i>Tall</i>		Nov. 8, 1983			12:20 A.M.		
3 SEX	4 RACE			5 DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
<i>male</i>	CAU.			MONTH MAY DAY 7 YEAR 1922			61			MONTHS	DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER		
MARYLAND	U.S.A.									MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			DORCHESTER GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
CAMBRIDGE							waterman & worker			Wire Cloth		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13 STATE MARYLAND	13b. COUNTY DORCHESTER	13c. CITY OR TOWN TODDVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS BOX 206, Toddville, Md. 21672						
14 FATHER'S NAME FIRST HARLEY	MIDDLE	LAST TALL	15 MOTHER'S MAIDEN NAME ALVERTA			LAST MEREDITH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO. YES WW II 220-10-6793			17 INFORMANT wife Betty Abbott Tall, same as 13e			ADDRESS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <i>4100</i> APPROXIMATE INTERVAL Conditions, if any, which BETWEEN ONSET AND DEATH gave rise to immediate cause (a), stating the underlying cause last												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial Infarction</i> 3 hrs. Coronary Heart Disease 44 yrs.												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN				
22a. I certify that (I) (this hospital) attended the deceased from <i>11/8/83</i> , 19					to <i>11/8/83</i> , 19			that (I) (we) last saw the deceased alive on <i>11/8/83</i> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Lawrence Marynor</i>		22c. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>11/8/83</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lawrence Marynor MD</i>		22e. ADDRESS <i>610 1325 St Cambridge, Md 21613</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Nov. 10, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Pk.			23d. LOCATION CITY OR TOWN Airey, Cambridge, Dorchester, Md.				
24. FUNERAL DIRECTOR NAME <i>Curran Funeral Home, 308 High St., Cambridge</i>		ADDRESS Md. 21613			25a. DATE REC'D. BY REGISTRAR NOV. 9 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Curran</i>				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 30249						
1 - STATE REGISTRAR												2b. HOUR ? M						
1. DECEASED NAME (TYPE OR PRINT)			FIRST RICHARD			MIDDLE LEE			LAST TRAVIS			2a. DATE KNOWN OF ESTI. DEATH MATED X 11-17, 83			2b. HOUR ? M			
3. SEX MALE		4. RACE CAU.		5. DATE OF BIRTH MONTH DAY YEAR MAY 20, 1950			6. AGE (IN YEARS LAST BIRTHDAY) 33 YRS.			7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Nov. 18, 1983			2d. HOUR 8AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER											
10. CITY OR TOWN OF DEATH CAMBRIDGE			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION DORCHESTER GEN. HOSP. (pro. dead)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) self-employed			12b. KIND OF BUSINESS OR INDUSTRY waterman			
13a. STATE MARYLAND			13b. COUNTY DORCHESTER			13c. CITY OR TOWN TAYLOR'S ISL.			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS rural Box 43 21669			MD.			
14. FATHER'S NAME FIRST SAMUEL			MIDDLE B.			LAST TRAVIS			15. MOTHER'S MAIDEN NAME FIRST LULA			MIDDLE			LAST TRAVERS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 216-56-1520			17. INFORMANT father			ADDRESS Md. 21634			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Mins.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: 9554 IMMEDIATE CAUSE (a) Bullet wound of heart Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ?PM 11-17 1983			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self inflicted gun shot wound.			21d. LOCATION STREET Hoopers Town Road Taylors Is. Md.			COUNTY STATE Dor						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home			21f. TITLE (SPECIFY) Deputy			M.D. MEDICAL EXAMINER			DATE SIGNED 11/21/83						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																		
ACTUAL SIGNATURE <i>John Mace Jr.</i>			EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr. M.D.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE Nov. 21, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Pk.Cem.			23d. LOCATION CITY OR TOWN Airey, Cambridge, Dorchester, Md.			COUNTY STATE Cambridge, Dorchester, Md.						
24. FUNERAL DIRECTOR NAME Curran Funeral Home, 308 High St., Cambridge,			ADDRESS Md. 21613			25a. DATE REC'D. BY REGISTRAR NOV 28 1983			25b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>									
BP _____			DHMH-17 (VR A15 ME (5)) 15M 2/80															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 30250			
1 - STATE REGISTRAR			2a DATE OF DEATH 11 3 83									2b. HOUR 6:20 PM			
1. DECEASED NAME (TYPE OR PRINT)			FIRST Beulah R			MIDDLE			LAST ward						
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH 7 DAY 25 YEAR 21			6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.						
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker			12b. KIND OF BUSINESS OR INDUSTRY						
13. STATE Md.		13b. COUNTY Dorchester		13c. CITY OR TOWN Secretary		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 21664						
14. FATHER'S NAME Harry			MIDDLE B.			LAST Insley			15. MOTHER'S MAIDEN NAME FIRST Rosa			MIDDLE Lee		LAST Jones	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 214-10-0887			17. INFORMANT Richard Insley			ADDRESS Box 13			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Infiltrating Duct Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>of left breast</u> 2 years															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Generalized Neurofibromatosis</u>															
19a. DATE OF OPERATION 9/24/82			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>carcinoma of breast</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 23, 1982</u> to <u>Nov 3, 1983</u> , that (I) (we) lost saw the deceased alive on <u>Nov 3, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Lewis M. Burdette, M.D.</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>11/13/83</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Lewis M. Burdette</u>			22e. ADDRESS <u>4 Aurora St</u>			22f. LOCATION CITY OR TOWN <u>Cambridge</u>			COUNTY <u>Md.</u> STATE						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>			23b. DATE <u>11/5/83</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>DOR. MEMORIAL PARK</u>			23d. LOCATION CITY OR TOWN <u>CAMBRIDGE</u>			COUNTY <u>DOR</u>		STATE <u>Md.</u>	
24. FUNERAL DIRECTOR NAME <u>THOMAS FUNERAL HOME</u>			ADDRESS <u>CAMBRIDGE, MD.</u>			25a. DATE REC'D. BY REGISTRAR <u>NOV 9 1983</u>			25b. REGISTRAR'S SIGNATURE <u>John J. Grimes</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. <u>30251</u>				
1 - FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
			<u>Larue Howard</u>			<u>Warfield</u>			<u>November 7, 1983</u>			<u>0300 M</u>				
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
<u>male</u>		<u>white</u>		<u>04 28 1901</u>			<u>82</u> YRS.			MONTHS <u>0</u> DAYS <u>0</u>		HOURS <u>0</u> MIN <u>0</u>				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.						
<u>Md.</u>		<u>U.S.A.</u>		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<u>Dorchester</u>									
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
<u>Cambridge</u>		<u>Dorchester General Hosp.</u>										<u>Loom operator</u>		<u>mfg.</u>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13e STREET ADDRESS				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS										
<u>Md.</u>	<u>Dor.</u>	<u>Cambridge</u>				<u>18 Algonquin Rd. 21613</u>										
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. SOCIAL SECURITY NO											
<u>John Holliday Warfield</u>		<u>Nettie Larue</u>			<u>214-07-8008</u>											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO			17. INFORMANT ADDRESS											
<u>No</u>					<u>Rachel H. Warfield</u> <u>Item #13</u>											
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypoxia, Shock</u> 4100 Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Inferior myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Heart Disease</u>												18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypoxia, Shock</u> 4100 Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Inferior myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Heart Disease</u>				
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>CHF.</u>																
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
					<u>N/A</u>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <u>N/A</u> CITY OR TOWN CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>10-6 1983</u> , to <u>10-7 1983</u> , that (I) (we) lost now the deceased alive on <u>10-6 1983</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												22c. DATE SIGNED <u>11-9-83</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
<u>A.R. White MD</u>		<u>400 Maryland Ave. Cambridge 21613</u>														
23a. BURIAL, CREMATION, REMOVAL (SPECIES)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY				23f. STATE		
burial		<u>11/9/83</u>		<u>Dorchester Memorial Pk.</u>			<u>Cambridge Dor.</u>			<u>Md.</u>						
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRATION REGISTRAR'S OFFICE											
THOMAS FUNERAL HOME		CAMBRIDGE MD.			<u>NOV 16 1983</u> <u>Jeanne</u>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and submitted in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 3 30252			
												REG. NO.			
1 - FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
			Witmer James Waters						11 10 83						230 PM
3. SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE			Negro			MONTH 10 DAY 30 YEAR 98			85 YRS			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
MARYLAND			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Dorchester						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Cambridge			Dorchester General Hospital retired						Farmer/laborer						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE 13b. COUNTY 13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
MARYLAND Worcester			Snow Hill			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. #3, Box 322 21863						
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
ISAAC			Sally Parker			NO			— — —			Rt. #3, Box 220 Snow Hill, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5609															
DUE TO, OR AS A CONSEQUENCE OF (b) cause unknown															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if lost															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
Dynamic Brain Syndrome, Electrolyte imbalance															
MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)									
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE G. Cannars			22c. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11-10-83						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 11-15-83			23c. NAME OF CEMETERY OR CREMATORIAL COOLSPRING U.M. Cemetery Girardtree			23d. LOCATION CITY OR TOWN Worcester			COUNTY	STATE		
24. FUNERAL DIRECTOR NAME Jolley Memorial Chapel Salisbury, Md.			R. J. Jersey Rd.			25a. DATE REC'D. BY REGISTRAR NOV 21 1983			25b. REGISTRAR'S SIGNATURE John G. Cannars						
BP _____															
DHMH - 16 50M 1/81 (VRA 15, 4)															

Enfield centre sandpit

By Mr. C. G. Smith

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